SurvivingWork

A Survival Guide

Contents

“Vulnerability has become associated with failure.”

About this survival guide

This Survival Guide is designed for our Survival Courses which aim to provide an accessible entry point for key workers and front line managers to survive working in health and social care.

We take a jargon free, de-stigmatizing and practical approach for addressing the real problems of working life such as how to get on with people at work and dealing with bullying cultures.

The proposal of this guide is that surviving work is essentially democratic - we can all experience periods of vulnerability at work but equally we can all do something about it. We take a relational model of work and emphasise that in order to survive work we all need to build our relationships with the people around us.

In order to do this we use the LAUGH approach which helps us understand our working environments, to talk to each other and to solve problems collectively.

We use the LAUGH approach which helps us understand our working environments, to talk to each other and to solve problems collectively. The LAUGH approach involves three steps:

Stage 1: Starting where you are by **L**istening and **A**ssessing what is going on at work and what level of resilience you individually and collectively have

Stage 2: **U**nderstanding your environment and identifying resources

Stage 3: **G**etting **H**elp from the people around you and working out how to have better relationships at work.

About Surviving Work

The aim of Surviving Work is to create a jargon free, de-stigmatizing and practical approach to surviving work. We use a combination of therapeutic and educational methods delivered face-to-face, online or through mobile technologies. Our approach is interdisciplinary, using ideas and practices from normally distinct disciplines of mental health, management and business and active learning methods.

You can find out more at the Surviving Work Library a free resource based on the experiences of people who are actually doing it.

Find us on www.survivingwork.org and @survivingwk or email us on info@survivingwork.org

The Author

Dr Elizabeth Cotton is a writer and educator working in the field of mental health at work. She teaches and writes academically about employment relations and precarious work, business and management, adult education, team working and resilience at work. She blogs as www.survivingwork.org and @survivingwk and runs the Surviving Work Library, a free resource for working people on how to do it. Elizabeth is a member of the Chartered Institute for Personnel and Development, British Sociological Association, Organisational for the Progressive Understanding in Society and the Association of Psychosocial Studies.

"Working in health and social care is a political thing. It doesn't matter what your ideology is, we're dealing with political phenomena like the winding down of the welfare state and the fact that 30% of health workers are also on benefits because they don't earn enough."

start where you are

It is a stomach-churning reality that the NHS rests on bullying the people who work in it. This "endemic culture of bullying" has facilitated a growing crisis of structural discrimination and racism, staff burnout and stress, and with it a risk to patient safety.

One of the most devastating examples of what can happen as a consequence of poor team working is the Mid-Staffs case, researched in detail by the Francis Inquiries. There is a direct link between working in a clinical environment where concerns cannot be raised and where bullying cultures exist and quality patient care. The ultimate problem with not addressing how our workplaces are functioning is that the patient gets to carry the consequences when we do not get it right.

As a society we have lazily allowed jobs in health and social care to become harder, sometimes impossible by playing games with health targets provoking an often deeply cynical response by clinicians to attempts to build their collective 'resilience'.

This is a response to two things. Firstly the rate at which changes are taking place in our sectors make it very hard for us to understand the climate that we're working in.

Secondly, most of the responses to the lack of our wellbeing at work are individualistic and emphasise individual survival strategies. Although its good to be able to regulate your emotions and give up smoking, most approaches ignore the systemic reasons why working in health and social care has become so hard.

Based on the principles of adult education, the first stage to building our capacities at work is to understand the realities of work. Whether you call it consciousness raising or just being informed, the first stage to tackling bullying is to understand your working environment.

The proposal of this guide is that the first step to addressing bullying requires starting where you actually are, rather than where you would like to be - looking realistically at our work environments as well as the impact that this has on us as individuals.

There is growing research about the systemic problems that have created a culture of bullying in the NHS. The proposal of this guide is that the following factors are key.

people get sick in a recession

In addition to the demands of an ageing population health and social care is having to address the impact of growing inequalities. As health inequalities become an everyday reality it gets harder to kick stuff under the public interest carpet. With the former chief economist of the World Bank on a book tour about the systemic failure of our economic system, you don't have to be Marx to think that a concentration of capital into 1% of the world's population is bad news for our collective mental and physical health.

The psychosocial consequence of not being able to access joined up health services is that people develop more complex and serious health problems, often ending up in A&E and police cells as a last resort.

This is not just a problem for patients but also the people delivering that care. If you go to the frontline two things are obvious. Firstly that the distress of patients

is, well, distressing and as demands go up on our health and social care systems so does the pressure placed on the people working in them. Secondly, that the compulsive drive for a 24/7 health system, combined with declining real wages and increased job insecurity then you don't have to be mad to work here but its extremely likely.

politically set targets & command and control management

It's pretty much a full time occupation keeping abreast of the changes in policy and professional standards in the NHS. To the extent that many of us working in health and social care are suffering from 'restructuring fatigue'.

The NHS has gone through three major periods of restructuring since the 1980s, involving privatisation and the introduction of the Public Finance Initiative (PFI) and decentralization of budgets, most recently establishing Clinical Commissioning Groups.

In part to prove efficiency and in part to reflect political priorities there has been a growth in nationally set productivity targets to measure NHS performance. Although there is no problem with setting goals and monitoring, the problem in the NHS is that this has been done 'top down' so that ministerially set targets have become vastly more important than the traditional clinical outputs.

One of the problems is that targets are politically motivated, passed down from ministerial to management levels without due consideration of local needs and resources. Since the NHS was created there has always been a tension between supply and demand of healthcare.

A staggering 20% of senior management positions remain empty in the NHS - a figure that goes up to 37% in mental health. One contributory factor is the brutal-

ity of the bullying culture that goes right to the top - reflected in the highly publicised cases of senior management turned into NHS whistleblowers.

Leadership vacancies are in part due to the fear of 'double jeopardy' when clinicians take up senior management positions. Nationally set productivity targets combined with austerity cuts have increasingly put clinical best practice in direct conflict with financial targets and encourages gaming - such as patients being parked on trolleys in hospital corridors to avoid falling foul of waiting time targets and early discharge of patients followed by quick and unreported re-admission.

Research indicates that managers under pressure to deliver targets typically default to a command and control management which is unresponsive to both patients and staff. Do-this-now rather than what-is-the-best-we-can-do. This, in turn, is linked to workplace cultures where staff are reluctant to raise concerns, and become disengaged and dysfunctional, a long way from best practice and patient safety.

rise in precarious work

In 2015 we saw NHS working conditions and contracts the subject of an important debate by the government's petitions committee after a petition opposing a 24/7 health service and a vote of no confidence in Jeremy Hunt.

The debate about precarious work is a defining one in the field of employment relations, making the research link between between nationally set cuts and targets, privatization of services and growth of externalised labour, the use of command and control management, work intensification and bullying cultures.

The growth of precarious work underpins the UK's mental health services. One third of people working in the NHS earn less than a living wage. With pay freezes and reduction in collective bargaining the real value of NHS wages have gone down over the last 5 years. Of the 1.4 million people working in social care, 160,000 are earning less than the minimum wage particularly domiciliary carers who are paid only for the 15 minutes of contact time and not their travel between clients.

Psychotherapists working in the UK offer us a graphic example of precarious work. A very important report has been produced by the British Psychoanalytic Council and the UKCP about the working lives of psychotherapists. It concludes that with a 77% increase in complex cases and 63% of clients reporting that NHS therapy was too short to do any good, the reality of working in mental health is that it is literally maddening.

The confusion and ignorance about the employment relations system of psychotherapists is very much about the continuous privatization and restructuring of the NHS and the 2013 shift of commissioning powers to local level. However it also exposes a range of employment relations problems faced by psychotherapists, including the growth of contract and agency labour, the use of unwaged labour, the insecurity of 'permanent' psychotherapists in the NHS and the retreat into private practice. We will look at each problem in turn.

In 2015 the use of agency nurses has had a lot of attention - with Simon Stevens, the head of NHS England, describing private employment agencies as 'ripping off' the NHS. In an attempt to get more nurses on wards the NHS bill for agency labour has doubled to 1.8 billion. Although looking at this problem is welcome, very

rarely do we think about how precarious conditions of work might impact the states of mind of the people working in health and social care.

In 2015 the Guardian's ClockOff survey came out measuring the stress levels of public sector workers. People working in health are the most stressed out public servants, with 61% reporting that they are stressed all or most of the time. This is not about failures of individual compassion or positive thinking, rather it highlights the impact of precarious work on our states of mind.

Not earning enough to live or having insecure contracts puts us in a precarious position and when we are precarious at work we are vulnerable to burnout, bullying and failures in our duty of care. Compassion is hard to squeeze out when you have not been able to afford lunch on a 12 hour shift.

decline in professional bodies and unions

One of the reasons for low wages in health and social care is the decline of professional bodies and trade unions that have historically fought for wages and conditions. In social care for example, the Social Care Association closed in 2012 and 2015 saw the closure of the College of Social Work set up after the case of Baby P. Both of these bodies provided the professional framework for their sectors, and both were closed due to pitifully small deficits in funding. If we had wanted to maintain these bodies we could have, easily.

In Julian Lousada and Andrew Cooper's important book Borderline Welfare they thoughtfully argue that when we lose the institutions of welfare we lose the general conditions that are necessary for care to take place. What we are left with is lots of activity that is done by increasingly vulnerable individuals trying to bridge a

massive governance deficit. By not maintaining the institutions of welfare the state fails in its duty of care to create the conditions under which health and social care work can responsibly be done.

A second problem is the lack of union power in these low wage sectors. Whatever your political view of trade unions, the reality is that the key reason why wages are going down is that precarious workers generally don't join unions, and are hard to mobilise around collective bargaining. There are over 200,000 active workplace representatives in the UK doing what they can to organise people into unions. Most of them do this without pay and for the right reasons. Whatever your politics, unions up until this point have been the only show in town in negotiating wages and their inability to defend the wages of health and social care workers is not a political problem but a genuinely social one.

why don't we care about carers?

One of the things that's almost always overlooked in the NHS debate is the experience of the people delivering these services.

There are three rather obvious reasons for this. The first is that the reality of working life is very low down on the political food chain in a system that is dominated by politically set targets and appeals to managerial efficiency. Employment relations just have not been considered important in the debate so far.

For example, the NHS's own workforce database did not collect information about its internal labour agency - Bank staff - until November 2014. They still do not collect information on the number of external contract and agency workers providing NHS services nor, more importantly, whether it makes a difference to patient care.

The second reason is that the people delivering these services are just too scared to engage in the debate. When you work in a precarious job you are highly vulnerable to precarious states of mind, completely counterproductive for people employed to contain the anxieties of others. It is not just the immigrant nurses working for private employment agencies that feel insecure, it impacts everyone working in this system. Precarity is inclusive, with even senior clinicians on permanent contracts unwilling to join the ranks of the self-employed by raising patient safety concerns with management.

According to the people working in it, the NHS runs on a 'pervasive culture of fear'. This is a culture where nobody can afford to make mistakes and people manage workplace conflict by keeping their mouths shut.

It means that people working in health and care are often disorientated by a sense of 'liquid fear'. A world of work where distinctions between serious and less serious workplace problems can't be made. The smallest mistake becomes the end of your career and you wake up bolt upright sweating at 3am wondering how you're going to handle the next 'informal' chat with your line manager.

This fear goes right up the management chain, with NHS leadership reduced to talking about the very evident financial crisis only from the safety of retirement.

A third reason why so little is known about employment relations is because of the nature of the work. Caring for people is not like working in IT. Emotional work has never been highly valued in our society, reflected in the bad pay and the ease with which emotional workers are blamed for systemic failure. Billions of budget deficits get passed down through decentralising commissioning, politically

set targets translated into work intensification, easier to blame a nurse than succumb to the anxiety of realising that our health and social care systems are failing.

When people are scared at work it results in witch-hunts, whistleblowing and tribal warfare. A working culture where staff meetings become an exercise in the yes/no game of talking around the elephant in the room, that targets cannot be met safely.

Whatever your politics, working in health and social care is political because our jobs are impacted by the wider societal and regulatory context. The proposal of this guide is that the more you understand this context the more able you will be to navigate bullying at work.

“A lot of people choose precarious work because they can get out of bullying in full time work. The problem is if they become sick or old.”

understanding bullying

Getting a perspective on bulling is difficult because it requires facing up to some hard facts of life - that bullying in the NHS is likely to get worse as the financial crisis deepens and that whatever our role we are all involved in bullying at work. Although bullying is not against the law, all employers have a legal duty to address bullying at work.

Bullying is not an exact science, it's something like "the repetitive, intentional hurting of one person or group by another person or group, where the relationship involves an imbalance of power" - underlining the structural inequalities behind bullying cultures and their impact on our health.

Understanding the dynamic nature of bullying - that it has systemic and individual aspects - can feel like an attack on the victim. You don't have to be Jeremy Corbyn to think that there's a connection between the austerity and bullying but how bullying has taken hold of the NHS requires further investigation.

Psychoanalytic ideas are profoundly helpful in helping us to understand how bullying has become established in a non-judgemental way - defining it as a psychological and social defence against our own feelings of vulnerability, anxiety and aggression. Under this model bullying is understood as an attempt to project our own vulnerability and fear into other people, something that under the right (or wrong) circumstances we are all capable of doing.

This is not to suggest that everyone is actually a bully - rather that bullying at work is painful in part because we are all involved. Whatever our role – the pa-

tients that stand by, the staff that turn a blind eye, the politicians that cut budgets and the bullies themselves - we all have a part to play in bullying becoming established.

Despite everything we know about the necessity of team working in health and social care, where bullying exists we generally don't challenge it. Common survival strategies include withdrawal from colleagues or to strike up alliances with people who offer us protection. This can include establishing gang-like ways of working - such as blaming and exclusion of people with different views or ways of working.

Gangs, unlike functioning teams, offer a mafia-like organisation where accepting the gang rules protects you from attack but demands utter compliance, a dangerous culture in healthcare where our duty of care demands we raise concerns about patient care.

Another important dimension to bullying is what happens in the mind of the victim when the bully launches their attack. One of the reasons why bullies get under our skin is because they enlist our internal bullies - the voice inside our head which actually agrees with the external bully.

How to bully someone at work

- *subject individual to constant criticism*
- *increase the threat level incrementally*
- *marginalise, sideline and isolate*
- *undermind the person's position, remove status, perhaps through 'reorganisation', 'rationalisation', 'efficiency'*
- *ignore and humiliate the individual in meetings*
- *appoint to a dud project or position which ends soon*
- *set tasks which are impossible to achieve, then claim underperformance*
- *make all tasks unnecessarily complex and withold necessary information, then claim underperformance*
- *repeat the above*

Amended from Tim Field's Bully in Sight

Not wishing to look like I'm punching kittens, in the case of health and social care workers, this internal voice can be loud efficiently disorienting us and undermining our self-confidence.

Understanding the dynamic nature of bullying - that it has systemic and individual aspects - can feel like an attack on the victim but its a risk worth taking because it is by understanding the nature of bullying that we can start to tackle it.

Sweat the small stuff

Having the dubious honour of working on bullying at work for some time, I'm going to do something that I don't normally do which is to give you a checklist. It is premised on one simple principle - that tackling bullying requires sweating the small stuff and taking some small practical steps.

Typical Bullying Behaviours

- *constant criticism which is inconsistent with reality*
- *humiliation in front of others*
- *deliberately undervaluing the value of someone's work*
- *demotion - real or implied*
- *putting people into solidarity confinement and excluding them from contributing to work*
- *threats of disciplinary action for small or unsubstantiated incidents*
- *refusal to discipline other staff for bullying behaviours*
- *not explaining or giving training for new responsibilities*
- *changing job description without consultation*
- *refusal to talk directly or confirm in writing any complaints about work*
- *aggressive behaviour*
- *ridiculing, sarcasm, use of offensive names, jokes and language, spreading gossip*
- *holding meetings, the purpose of which is not clear and with short notice*
- *refusal to minute meetings or allow representation at meetings*
- *contacting employees at home or on holiday or sick leave with 'urgent' work*
- *coercion into doing work that disregards rights and job descriptions*

Amended from Tim Field's Bully in Sight

Step 1: find some higher ground

Being bullied feels like drowning so you first need to get to safer ground. This involves getting out of bullying hot spots; anything from avoiding the smoking breaks or those after work drinks that seem to end up with someone calling you fat and ugly. Or it can be going somewhere every day where you feel safe - from your best friend's sofa, to train stations or allotments.

Stage 2: bullying book

Methodically write down the times, places and what happened every time you were bullied. Not everything is subjective, there are facts about bullying behaviours so write them down. Keep the book at home and only ever open it when you're in a robust frame of mind and definitely when you are not drunk.

Stage 3: get a witness

It is essential that you tell someone what is going on. They can be someone that has witnessed the bullying or not, someone you like or not, but someone who you trust to keep their eye on you. Telling someone does a number of things. It forces you out of your bunker and makes you admit what is happening.

Be a pedant

Before you enter the confrontational ring there are important factors you need to consider:

- *have you logged accounts of meetings or exchanges in which you or your professional competence were verbally attacked?*
- *Do your notes contain dates, times and locations of every slur on your character, or on contributions you have made under your job description?*
- *have you retained copies of annual appraisals or letters relating to your ability to do your job?*
- *are you keeping copies of all memos sent by your boss? do you know your precise job description? are your responsibilities in line with it?*
- *if you are relatively new to the job, would senior colleagues be prepared to support you and insist that there is nothing wrong with your work?*
- *are you feeling physically and emotionally well enough to confront a person who has already affected your health, and inflicted a punishing swipe on your self confidence?*
- *are there others who have suffered as you have who might be willing to support you?*

From Andrea Adams & Neil Crawford's Bullying At Work

Stage 4: phone a friend

Whether you are a victim of bullying or trying to help someone who is there's a huge temptation to withdraw from other people. So this brings us kicking and screaming to a really obvious fact of life. Tackling bullying requires doing something totally counterintuitive - making contact with other people and asking for their help. In a bullying workplace, joining a group can give us a profound sense of place and support to make changes. Trade unions are often good at dealing with bullies – they don't like em, and reps can be dogged in their devotion to shouting back on our behalf when we can't summon up the strength to do it ourselves.

If you can regain your humanity by taking some small steps you will then be in a better position to make the bigger decisions about how to tackle bullying at work.

Acknowledging that bullying is an ordinary part of working life is not the end of the world nor does it inevitably mean you have to walk away from your job. Ironically the strength needed to face up to bullying involves accepting both our power and vulnerability. As any clinician will know, the work of helping other people involves helping ourselves, which turns out to be the hardest part because it requires us to put aside our shame and ask another human being for their help.

"We're working in a culture of bullying and fear. And most people shut up. Because people are working in silos they're not used to talking to each other. They're certainly not used to disagreeing with each other. Particularly when it comes to the huge conflict between the clinicians and the finances in the NHS."

Understanding discrimination

Harassment as a form of discrimination is unlawful - enshrined in the Equality Act 2010 - and, although there is no specific legislation against bullying, the are anti-discrimination laws and policies which identify disability, sexuality, religion or belief, class, age, gender and race as potential bases of discrimination. In addition, employers have legal duty to protect the health, including mental health, and safety of workers whether directly employed or not.

For a good basic guide on discrimination at work we recommend the TUC's Your Rights at Work and the Labour Research Department's Bullying and Harassment at Work. In the last section we have listed some really useful union guides on tackling discrimination - sometimes called 'dignity at work'.

Legal Responsibilities of Employers

- *Employers have a duty to prevent harassment, bullying and discrimination at work*
- *You are covered by anti-discrimination law from day one and even from the day of your interview*
- *You are covered against victimisation for raising a complaint*
- *Employees can bring complaints under laws covering discrimination and harassment, health & safety and unfair dismissal*
- *The 'protected characteristics' in The Equality Act 2010 are gender, pregnancy and maternity, race, disability, sexual orientation, age, gender reassignment, marriage and civial partnership, religion or belief.*

The problem of racism

Despite the blinding evidence, very few of us talk openly about the reality that the NHS is, in fact, institutionally racist. Roger Kline's research - famously describing NHS leadership as "the snowy white peaks" - has let the cat out of the bag.

Despite 41% of NHS workers in London being from a BME background and a lot of equalities work over the years

- the proportion of London NHS Trust Board members from a BME background is 8%

- white staff in London are three times more likely to become senior managers than BME staff.

- 25% of BME staff consistently report they are discriminated against at work

The NHS's own workforce surveys show that **BME staff** who are more likely to be bullied at work and subject to disciplinary processes. The moment has come when we have to ask, do black working lives matter in the NHS?

Very much if you're a patient in the NHS. The discrimination against BME staff is not just an employment relations problem, its a clinical one. The treatment of BME staff is a good indicator of the quality of **patient care**.Re search, much of it being produced by the **Kings Fund** and **Michael West's** research team, shows that when BME staff are treated unfairly this is reflected in poor patient care. This is linked to our experience that a lack of diversity in teams reduces innovation and learning and that when staff don't represent their local communities they struggle to provide genuinely patient centred care.

However despite overwhelming opposition, the Government repealed the third party harassment provision under the Enterprise and Regulatory Reform Bill from

How to protect people that are being bullied

- *That the bully is being transferred to another section or another department on the same site, or to another branch of the organisation*
- *That whatever happens, they will remain safe*
- *That until further notice, any attempt by the bully to make direct contact with previous colleagues, other than through an appointed third person, will result in disciplinary measures*
- *That this person is made fully aware of the effect their behaviour has been having on others*
- *That the bully is being helped to unlearn his or her aggressive behaviour style – and how*
- *That until those responsible for human relations are satisfied that the individual concerned has been successfully retrained he or she will not be put in a position of managing other employees.*

April 2014. The government said that "it is unfair that employers should be liable for the actions of third parties over whom they have no direct control. However, there is protection from Third Party Harassment from the EU Equal Treatment Directive.

Workforce Race Equality Standard

Earlier this year, the **Workforce Race Equality Standard** was announced to tackle equal access to career opportunities and fair treatment in the workplace for BME staff. It provides a measurement for workforce equality and a requirement for NHS trusts and employers to deliver results - neutrally named the Equality Delivery System or EDS2. These measurements will be used by health regulators to measure equality in the NHS.

Potentially this sounds a bit dull - but having standards, measurements and tracking data is extraordinarily necessary given the reality that nobody wants to talk about racism. The NHS has until now relied heavily on not collecting data, not publishing it and therefore not having to acknowledge the problem in the first place. Data is good.

Taking Legal Action

Taking a legal case is generally considered to be the last resort when everything else has failed. There is a nationally set 'three-step' procedure for dealing with dismissal, discipline and grievance issues which must be followed before a legal case can be taken. They are:

- *Completing a statement in writing outlining the grounds for grievance*
- *Carrying out a meeting between the parties involved*
- *Carrying out an appeal if requested after this meeting*

If the grievance process fails then you can make a claim to an employment tribunal within a 4 month period

Not only that because data drives inquiry. In every other aspect of NHS life – disease, patient safety, improving care - we use data to identify problems and

make changes. If workforce race discrimination adversely impacts patient care surely data on racism should be treated the same way. This is what the Standard is starting to do.

The emotional reality of dealing with racism

But once the data comes out we are still left with the enormous difficulties NHS staff are going to have in trying to tackle racism at work. The data doesn't express the deep and difficult emotions that are inherent in experiences of discrimination. Bluntly, racism is underpinned by a hatred for other people and the rage at being on the receiving end of it.

When the issues at work get this tough we need to wheel in the big psychological guns.

Psychoanalytic ideas are really helpful in thinking about racism. A much discussed idea developed by Fakhry Davids relates to the **Internal Racist** - the part of all of us that hates difference in others. Within this psychoanalytic model, we start with the basic belief that we all have an internal drive to hate difference in others, a feeling that is provoked under stress and situations of scarce resources.

Taking the next step

The next step to tackling discrimination could be to put in writing your concerns to the person involved.

Dear …

I am writing to complain about what you (did/said) to me (on date/yesterday/this morning when you …

Over the previous months you have …
I want you to stop this behaviour now/calling me …

I find this offensive and unnacceptable. I am keeping a copy of this letter and I shall take further action if you do not stop immediately.

Yours sincerely,

…

When we encounter differences in others, particularly if we don't like them or are working in a workplace in conflict, the psychic process can go as follows:

- something gets challenged - a belief, a comfort zone, a value, a clinical practice
- we become offended
- we get angry
- we become hateful towards the people around us
- we then experience a paranoid guilt that the other person is going to retaliate
- we get defensive and possibly a bit hostile

In most cases our egos cant handle this decline into primitive feelings and we deal with feelings of hatred by withdrawing from other people. This dilutes the strength of our ugly feelings but it also allows us to keep our views unchallenged and our superiority intact.

Psychoanalysis promotes a model of development which is about taking a view of the world that is not black and white. Growth involves a psychologic process of moving away from a perspective where people like me are good and people who aren't like me are bad, towards a more depressive position that we are all a mixture of good and bad aspects. This more balanced perspective about the world allows us to reduce the very human default position to project our angry and negative emotions into other people. The argument is that by accepting we are all able to hate and love people we can then take some kind of ownership of the destructive emotions we all have to deal with in adult life.

If you work in health and social care dealing with diverse people is the nature of the job and, whether they're patients or colleagues, you don't get to walk away from them just because you don't like them.

Working with people who are not exactly like us and are in pain and distress means that being offended by others is an occupational hazard. The issue is not whether we will be offended, rather what we do with the offence. If we nurture it and leave it unchallenged it can turn to a hatred and a righteousness and work-places where some people are believed to be inherently better than others.

Equalities data and standards are crucially important in maintaining the battle lines between offence and hatred - but we can only do this, really do this, if we are prepared to know our internal battle with difference, and keep the internal racist in its primitive place.

“A lot of us who work in health have superegos the size of tanks. We’ve got this strong internal voice that says you must be right, do everything. Over time that can wear us down and make us very vulnerable to the external voices that say be ashamed for not being perfect.”

Protecting yourself

The 2015 announcement of a £5 million scheme to build the health of our 1.3 million NHS workers is an attempt to address a real problem.

The data around the health of health workers is contested - not least because of the immense difficulties and shame attached to clinicians admitting that they can't make it all better even for themselves. But we do know that specific groups, such as GPs, are increasingly vulnerable to burnout and depression - with particular groups such as trainee doctors and women GPs most vulnerable to suicide - and that this problem is likely to get worse as the demands placed on GP surgeries go up.

The lack of visibility of this initiative indicates one of the problems we have in keeping ourselves healthy. Culturally we find it very difficult to regard health and social care workers as ordinary human beings preferring instead to see them as Superheroes .

Health and social care workers hold a difficult position in society. We have to be authoritative and have all the answers - a surgical model where clinician removes the tumour and cures the patient. But we also have to be able to do a more delicate job of work to heal our patients' minds and bodies which are both always involved in the process of getting better. This is a delicate procedure requiring sensitivity, diplomacy and a big dose of humanity. It means that we need to be very much human beings.

There is something about people who go into health and caring professions that can make us vulnerable to the societal attack that we are under. By nature of the training, it attracts people with massive superegos that bark demands for super-

hero acts. We make massive demands on ourselves - an internal script of do-this-now-! rather than what-can-I-realistically-do-?. For many, professional training is an entry into the Cult of Perfection where such massively bright and capable people become highly vulnerable to fantasies of omnipotence. Add to that the years of working in climates where human error and fragility is not tolerated and you might need a God Complex just to get to Friday. As a result, its possible that many of us working in health and social care may not always be in a great position to assess our own mental health.

It's also the case that in order to survive work we need defences. As a clinician you have to put on a psychic white robe and adopt a position where in the interests of the patient you have to do stuff that they don't want you to do. Putting it bluntly, a lot of medical treatment hurts and involves getting patients to do things they don't want to do. From heart medication to losing weight the Doctor sometimes has to know best and have the authority to defend that position with the patient.

At the same time health and social care workers cannot always be so defended that they are unable to respond to the patient with some degree of curiosity and compassion. By being cut off from patients the real problems can get missed. This is particularly the case with mental health where the psychosomatic complaints we innocently take to our GPs are sometimes code for distress.

It takes a real human being to spot the human in others so health and social care workers have to be defended enough to treat the patient even when it hurts but not allow those defences to become so brittle that they cease to care.

It means that the optimum situation is that health and social care workers can shift their roles and ways of working within every working day. Robust enough to

treat a patient that doesn't want to hear it and emotionally engaged enough to actually listen to the patient who doesn't know what's wrong.

Based on the experience of people working in health and social care, here are some initial steps towards protecting yourself at work.

1. Start where you are

When it comes to surviving work we have to first be clear what the problem is. On an individual level this means taking a look at where we really are in life.

This sounds obvious in the cold light of day but a very human defence against disappointment is to pretend that things are better than they are. One of the reasons for this is that it requires admitting that you are an ordinary human being, who sometimes feels vulnerable and does not always have a solution.

Being an ordinary human being often cuts against our culture, particularly in health care where the pressure is on to always do more work and not make mistakes. Although this is impossible to achieve it is an important motivator and driver within clinical work and it is something we have to overcome if we want to get a realistic idea of where we really are in life.

The second difficulty in facing up to where you are in life is that it often means we have to confront difficult emotions, such as anger. This is a tricky one for clinicians because although we might be very good at dealing with other people's emotions, it's much harder to confront our own. Some of us can feel humiliated that we experience the same problems as our patients.

Most workplaces are also very demanding about how we communicate - with some taboos about showing emotion, particularly negative ones. However, in or-

der to really understand our own states of mind we have to be able to look honestly at how we feel.

2. Setting your limits

The second important stage of protecting yourself is to set some boundaries for yourself about when and how you are going to work. Establishing a sustainable way of working requires being realistic and accepting that you cannot do everything. Again, it is important to show yourself some compassion here, rather than listening to an internal voice which can often moralise or bully us into doing the right thing when it is not right for us.

Setting limits can also mean disagreeing with a workplace culture that does not tolerate limitations. Although being human means accepting that we are not superheroes it is a surprisingly difficult thing to get your head around. This is compounded by some workplaces having a "sink or swim" mentality with the 'ideal' doctors firefighting, saving lives and changing the world.

Although there is a real need for health and social care workers to be resilient this toughness is not a substitute for good mental health because it denies hard realities of time, resource and emotional limitations.

The main point here is that it is important to stand up to unrealistic demands and to stand firm on what you believe is a sustainable framework for you. This might involve setting a time limit for responding to emails, keeping your private number private, and being explicit about tasks or areas of work that you are not comfortable doing. It might not make you popular but it will help you survive work.

3. A protective approach

Most of us have a mixture of risks and protective factors in our lives and central to a protective approach is being able to identify what they are and how to manage them. Some things are not easily changed, such as disability or housing, but other factors we can influence to reduce our risks and increase our protective factors.

In a context where 74% of GPs said their workload was unmanageable there are going to be days when the suggestion that you might want to drop a few pounds and go to Zumba at the end of surgery might be met with something pretty hostile. However, we all have habits and behaviours that undermine our capacity to stand up for ourselves and whatever your view of the systemic causes of bullying these will need to be addressed as well.

One of the most obvious and difficult risk factors are toxic coping strategies, which can range from using alcohol or drugs, to burying ourselves in work. Addictions function to help us

Protect yourself

Before you embark on your campaign you need to make sure you are protected

- *if counselling is available make an appointment and talk through your experience - this can be either a work based programme or in your area*
- *tell your doctor what is happening to you at work*
- *make a conscious effort to eat a balanced diet to try to keep well*
- *avoid taking tranquillisers or antidepressants. They may make you feel less able to maintain a good performance at work, just at a time when mistakes will attract the bully's unwanted attention.*
- *learn how to relax. If no relaxation classes are offered locally, cassettes are available for home use.. This is a productive use of going online*
- *try to keep your sense of humour - get out, see friends or go online.*
- *maintain contact with friends outside work. You will need good listeners however deflated you might be feeling, make time to do the things you enjoy doing outside office hours.*
- *give yourself treats*
- *consider assertiveness training if it is not being offered by your organisation. It will help you to comp more effectively in the future*

From Andrea Adams & Neil Crawford's Bullying At Work

cut off emotionally as a way of managing anxiety. It means that we become numbed to what is happening around us and internally.

All of us at certain points need to have coping mechanisms and things we can rely on to help us deal with anxiety and the pain that it causes. This is particularly the case with over-work, which most people do not address because it is a 'socially acceptable' defence and often encouraged by workplace cultures.

However, inherent in toxic coping strategies is a paradox in that they actually make us less able to cope over time, because they undermine our self-confidence. Addiction involves a series of blackmails that if you challenge the dependency then you risk losing everything, or at least that is how it feels.

What we do know is that unless we tackle our toxic coping strategies things are likely to get worse so a key part of protecting yourself is going to be finding people and services that can help you overcome any bad habits that you have.

4. Next steps

Consciously knowing about and addressing our risks and protective factors is an essential part of protecting ourselves because it is on the basis of what we really know about ourselves and our environments that we can adopt some meaningful ways to improve our own resilience.

It is not enough to understand bullying; the aim is to tackle it without massively injuring ourselves. This means that an important process is planning your next steps.

Probably the most helpful advice will be from people who are experiencing the same issues as you and there's a list of some places you can start at the end of

this guide. Over 75000 health workers use twitter so there are a lot of additional resources and campaigns online which you might find helpful in establishing your next steps.

5. Having someone you can rely on

Getting help is probably the most important factor in building your capacity to deal with bullying. This is difficult for everyone, principally for two reasons. The first is that it means admitting that there is a problem that you cannot fix alone. Most people working in health will find it difficult to reach out to other people, because it's something we do not normally do. Additionally, not coping at work can leave us feeling isolated and alone making it a huge effort to articulate a problem to someone else. As a result people often retreat into a psychic bunker and completely cut off from other people.

The second issue is finding the right person or people to help you. The selection of people or organizations is important because they need to be someone that we trust and think is on our side. Although most people would like to call on their family and close friends sometimes it can be difficult to know who you can go to. Sadly romantic ideas about love conquering all are tested when feelings get stirred up- often rather unattractive ones like irritation and anger.

Sometimes, help comes from people that we may not immediately think of. It is important to think about people that you have relied on in the past and what specific help at work you need. Often these people can be colleagues, and it is important not to discount asking for help just because you are not closely connected on an emotional level.

Trade unions are central to protecting members - as the largest membership organisations in the world their experience of handling difficult situations at work is unparalleled. There are over 200,000 trade union representatives in the UK, ranging from elected leaders, paid officials to lay representatives. All of them deal with the daily realities of conflict, redundancies, grievances and the increasing crisis of mental health at work. A good place to start to look for support would be to contact your local union representative.

The main thing is to make sure that you take the important step of enlisting others to help you because it radically increases your likelihood of surviving work. You can do this informally or look to establish a formal mentoring relationship or make use of your professional memberships. However you structure this, it is important to work out who you think you can rely on and talk to them about your situation. In the main, people respond well to requests for help and often are flattered to be considered a friend and mentor.

6. Surviving is an ongoing process

There is no one-fix measure for surviving work because the key is about our capacities for adapting to change. This means that, by its nature, surviving work is a process of knowing where we really are, managing our risks and protective factors and being realistic about what we can do for ourselves and other people. This approach to our own resilience then provides us with the basis for helping other people build their own resilience. We should not feel like failures because of the reality that we have to keep addressing our capacity to survive work throughout our careers.

7. how we treat each other matters

Most people want to get on with the people around them but find it very difficult to do. Especially during restructuring and when hierarchical systems of

management are in place it is difficult to maintain good communications within our own teams.

The reality is that communication between clinicians, especially across disciplines is crucial to good patient care. The research, much of it carried out following the Mid-Staffs scandal, indicates that when we retreat into occupational silos and allow bullying cultures to establish themselves more clinical mistakes and accidents will happen.

In mental health, clinicians often make use of Clinical Supervision Groups, where small groups of clinicians meet on a regular basis to discuss cases. These are usually facilitated by a senior clinician and each member takes it in turn to present cases and critical incidents to the group. Clinical Supervision Groups are crucial to maintaining communication between teams, and also for building team working. There are models of running supervision groups which emphasise the emotional and psychological impact of dealing with cases, predominantly used in psychotherapeutic and psychoanalytic settings.

In a conversation we did for this course about the working lives of GPs we talked to Clare Gerada, who is a GP and works with the NHS Practitioner Health Programme and Chris Manning from Action for NHS Wellbeing, a network that works for a healthy workforce. These people are of the brave and humane variety. Willing to talk about their own states of mind and at the same time possessing the brass to shout loud at policy and committee meetings where talking about depression and burnout is received like a fart in a lift.

Both organisations offer support to individuals but more importantly they offer an invitation to GPs to form relationships with each other where the reality of their situations can be known without shame.

The increasing uptake of these two networks remind us of the possibility that health and social care workers can operate on these different levels but in order to do this requires more than just helping individuals and also requires a coordinated and collective response.

The existence of practitioner networks, whether its at the level of professional bodies, unions, support groups like these or online networks - is not just of therapeutic importance, its also of political importance. Because until health and social care workers can openly challenge this system of impossible targets, they cannot establish a profession worthy of them. This means moving beyond the individual towards developing relationships with the people we work with that are sufficiently strong to challenge the demands being placed on us.

The new occupational health scheme is a possible opportunity but as the crisis deepens, how we treat each other matters more.

“Receiving help is very difficult. There’s tremendous ambivalence about recognising we need help. We attack the helper as a way of covering up the shame of needing help.”

Duties of Care

The Duties of Care

Tied into the debates about compassionate care is the Duty of Care, a complex mix of rules and regulations that apply to NHS staff. Every health and social care professional and manager is responsible for legal duties of care, including professional codes, articulated in the newly amended NHS Constitution. It means that people working in health and social care have a personal duty of care to provide good clinical care and with it a Duty of Candour to raise concerns about poor practice.

This is acknowledged in the Government's response to the Morecambe Bay investigation and the recent Freedom to Speak Up freedomtospeakup.org.uk recommendations which include establishing a system of Guardians in the NHS.

The high profile NHS failures in the duty of care http://ww4.midstaffsinquiry.com point to a real problem in getting people to speak up at work and the severe limitations of a purely regulatory system that doesn't address the real reasons why people aren't raising their concerns.

In first place, is the fear of victimisation from colleagues and employers. This led to the Freedom to Speak Up review http://freedomtospeakup.org.uk that concluded that in order to get people to speak up the blame culture in the NHS needs to be addressed https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403010/culture-change-nhs.pdf .

This problem is often framed as the need to make the shift to a 'just culture' - one that makes a distinction between at-risk or reckless behaviour from just hu-

man error. A working culture that looks systemically at care, rather than taking the witch hunt school of management which individualises collective problems.

Candour in a context of austerity

The most common concerns in health and social care relate to connected issues of changes in service delivery such as outsourcing, work intensification, staff shortages and insufficient skills mix http://www.theguardian.com/healthcare-network/2013/may/28/guarantee-healthcare-workers-duty-of-care.

In a context of austerity one of the difficult areas for staff is whether to raise concerns over a lack of resources. The professional advice is that if you know that there is a serious problem with lack of resources and prioritising them then you are obliged to raise your concerns. This puts health and social care workers in, at best, a political position and at worst an impossible one.

NHS Constitution

The NHS Constitution sets the principles for how health care is delivered. It was amended in 2015 to respond to the Francis inquiries and includes a requirement for:

- *patient involvement*
- *feedback*
- *duty of candour*
- *complaints*
- *staff rights, responsibilities and commitments*
- *dignity, respect and compassion*

For health and social care professionals, the duty of care could mean refusing an instruction where you believe they have been expected to breach their professional code. In this situation, the professional is personally accountable for following their professional code and obliged to refuse instructions on the basis of their duty of care.

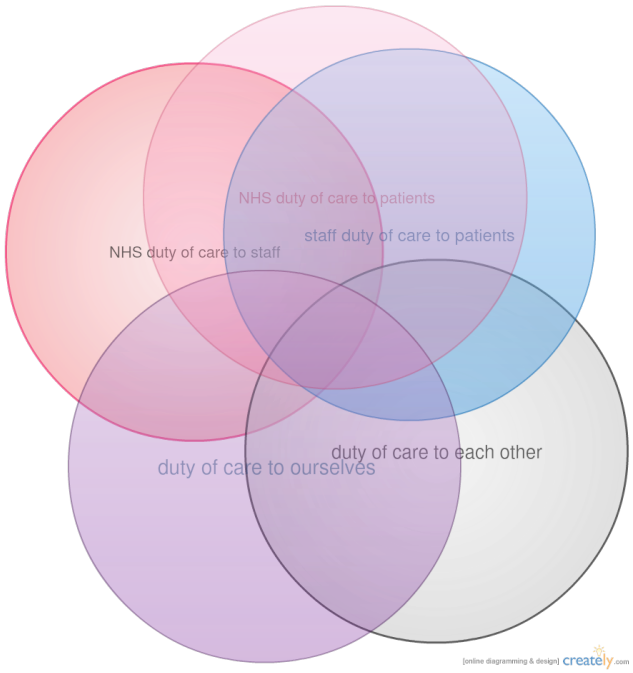
Only martyrs need apply.

The new regulations on our duty of candour, although well meant, add a further nail to the transparency coffin - making the focus on establishing the crime and the punishment, rather than the pressing problem how to tackle the culture of fear that they work within.

The Francis inquiry shows that where bullying and racism exist mistakes really happen. If our response is to regulate and punish alone, we are just setting up a system where silence is institutionalised.

A Relational model of care

I'll admit I love a good diagram, especially of the Venn variety. Benign shapes which help us look at the ugly reality that providing care presents difficult choices for health and social care workers between duties of care to patients and to themselves.



One of the problems with the current marketed and legalised model of care is that it creates splits - between colleagues and between staff and patients - and de-emphasises the important duty of care that staff have to each other. The reality is that if we are to improve clinical practice staff have to be able to form relationships that are strong enough to manage difficult conversations about the mistakes and unfair choices that are inherent in the job.

Against a marketized model of care (I sell stuff, you buy it) stands a relational model of care where our relationships with each other - with patients and between staff - takes priority in the design of services.

Working intimacy

Given the emotional nature of the work of care, you'd think we'd all be experts in forming relationships. But most working people cope with conflict and group dynamics by withdrawing into a 'bunker' - a safe place not disturbed by actual other people.

Drawing on the psychoanalytic concept of 'working intimacy', developed by a practitioner Angela Eden, is really helpful here. Within this relational model of work, getting on with people at work involves three things: putting the job of work back in centre place and then agreeing some common principles that set the battle lines between what's fair and what is not.

Because our principles in health and social care are compromised every day, these two elements can only be protected if we have genuine and functioning relationships with the people we work with. The third element of working intimacy is therefore that we have to get on with having actual relationships, and in most of our cases this means building our skills.

One of the difficulties of getting on with people at work is that for many of us working in health and social care we've got superegos like tanks - the internal voice that sees things in absolutes of right and wrong, black and right - you-must-do-this rather than what-is-realistic. It means that on an internal level, giving good care means challenging our internal Judge Judy and the part of us that wants to blame and shame others more than we want to understand them.

In this relational model, our capacity to deliver care and its associated duties rest entirely on us having relationships at work where mistakes can be made, thought about and addressed without anyone being burned at the stake.

Solidarity is back in fashion

Solidarity is a central organizing principle for collective organisations and activists, involving both the principle of common action with others and the identification of one's own interests with theirs. Solidarity can be conceived in two contrasting senses: first, as a normative or moral principle which creates an obligation to support other people in case of need; second, as a form of 'enlightened self-interest' with only weak ethical underpinning, motivated by the belief that an injury to one is an injury to all.

We often move between these two different modalities, but as the economic and political crisis deepens there is often a pressure to deliver mutual and concrete outputs. From protecting people from victimisation to delivering a living wage in the NHS, we want to see solidarity in action.

Far from the 1970s, this model of solidarity is based on the premise that we are not the same. A modern reality that diverse workforces cannot easily be swept up in a sea of class consciousness. The good news is that solidarity is a robust idea because it exists precisely because we are not the same. It is a model of collective

action that argues that in order to defend fairness at work we have to stick up for ourselves, an idea of decent jobs and for a system that cares.

If the history of workplace organising is anything to go by this involves setting the battle lines - the principles that form the basis of care - and the conditions under which those principles can survive. The over-emphasis on what needs to be delivered for less money comes at the expense of doing this. This political deficit means that a central task for all of us, whether patients or clinicians is to take a position on the values that underpin the NHS and to defend them.

This is both a political and concrete task. To defend a principle of care that is fair both to patients and staff, and to build sufficiently intimate relationships where we can work responsively rather than defensively.

Surviving work in health and social care

Many of us working in the public sector walk the thin line of surviving work - at times our relationship with work is abusive, working without reward or a sense of belonging and taking the blame for someone else's actions. Materially and emotionally, the more vulnerable our own situation becomes the harder it gets to care compassionately about others.

So, in this last blog of the series, I'm going to summarise what I've learned from you http://survivingwork.org about how to survive work in health and social care

- dont blame yourself: understand the social, political and economic factors that make your work what it is
- dont keep calm and carry on: find a way to actually feel what you feel about that - from anger to the need to punch and spit, feel it and find ways to express it that wont end up with you losing your job

- dont be brilliant: resist the temptation to be a superhero and single handedly overcome the systemic failure of welfare capitalism. Try to be an ordinary person would you?
- dont go it alone: just stop fighting the obvious that you have to get on with the people you work with enough to talk to each other and where possible collectivise around what is important at work

Ultimately, surviving work depends on how we treat each other. It matters if you ask people how they are and listen to the answer, support someone with a concern at the next supervision or join a union. It matters that you feel you belong at work, and have enough connection with the people around you to ask for help or to offer it. Time to dig deep.

“The response to whistleblowers - shooting the messenger - is about what happens when people find that their “not-knowing” is challenged. One of the responses is to become forceful in blocking unwelcome knowledge.”

Speaking Up at Work

The third Francis report on how to build a safe NHS focusses on the problem of how staff can raise their concerns about patient care without fear of victimisation or whistleblowing – a last resort that happens only when there are no other adequate avenues to report failures.

The report, which took evidence from more than 600 people about their experiences in the NHS and another 19,000 from an online survey, says nothing new to those working in the NHS, where bullying is endemic and most people survive working in the NHS's "pervasive culture of fear" by keeping their mouths shut.

The third report goes to the real experts, the people working in the NHS. Hardly a radical idea, but chronically missing in an institution dominated by top down targets and feverish policy-level action, all of which has totally and utterly ignored the working realities of the people that are supposed to deliver them.

As a result, there's important stuff in the report about the reality of health and social care in the UK. Not wishing to blind you with all the research, there are some really bad jobs in the NHS. Take the billion-pound business of agency nursing. In an attempt to save costs, the way people work in the NHS has changed with a radical increase in temporary and agency work, outsourcing, zero hours contracts, work intensification and a decline in real wages.

These changes in the employment relationship have triggered changes in the duty of care towards patients, including projecting risks and duties away from the principal employer onto service providers and labour agencies. And the negative impact on patient safety of these trends is a growing theme in both clinical and employment relations research.

Along with the revival of discrimination and racism, and the emergence of command and control management, it is no wonder that most NHS staff are too vulnerable to speak up. Francis rightly says that any staff involved in raising concerns and whistleblowing will need therapeutic support to survive the brutal process ahead.

The Freedom to Speak Up Review

The FTSU report published in 2015 make a series of recommendations for all NHS organisations, including regulators. The CQC was charged with creating a national system of workplace Guardians in each trust overseen by a national guardian to oversee the set up of the system. At the time of writing this guide this system is being set up - and a good place to look out for an update is the NHS Employers website which has a good section on the initiative as well as some useful resources about raising concerns on their campaign page Draw the Line.

One of the important principles that came out of the review was that in order to get people to speak up the culture of blame in the NHS needs to be addressed. The argument is that although regulation is important, if the response to mistakes and poor practice is to blame and penalise clinicians then staff will not be willing to come forward. This is acknowledged in the Government's response to the review and guidance on implementing the Freedom to Speak Up recommendations .

It goes some way to explain the current interest in how to create 'just' cultures in the NHS where people can raise their concerns at work and teams can learn from them without blame. In the next section we look in some detail at the regulatory framework for our duties of care.

Whistleblowing in the NHS

Inevitably in cultures where raising concerns is blocked, a greater number of people are forced into whistleblowing. These cases have been high profile over the last five years and there is a greater understanding that whistleblowing has very poor outcomes both for the whistleblowers and the organisations they come from.

The 'whistleblowing law' - Public Interest Disclosure Act 1998 (PIDA) updated through the 2013 Enterprise and Regulatory Reform Act (ERRA) - covers all staff in the NHS whether directly or indirectly employed. This includes the introduction of redress for workers who suffer from bullying as a result of reporting a concern, meaning that co-workers can be held personally liable for harassing colleagues who raise concerns.

The Government also publishes guidance on the prescribed bodies that employees can go to raise their concerns if they are unable to raise issues directly with their employer.

For confidential advice and support about whistleblowing you can speak to someone at Public Concern at Work.

Guardian Angels

The Freedom to Speak Up (FTSU) report also includes all NHS workplaces nominating a Guardian, people who will be tasked with encouraging people to talk and to support staff, which has been given the go-ahead by ministers.

It is not the job of a Guardian to raise formal grievances or defend individual members of staff in cases of disciplinaries - this is the job of a legal or union rep-

resentative although it will be an important part of your work to form alliances with unions.

The central task of a Guardian - which is being developed since 2015 - is to create spaces and cultures where staff are able to raise their concerns - both informally and formally - without fear of penalty and where lessons can be learned about improving clinical care.

The key problem that Guardian's will face is how to get people to open up. Most people deal with conflict at work by withdrawing and keeping their mouths shut. In order to know what is going wrong at work the Guardians will need to do two things. Firstly to observe what is not said and look out for clues as to what is going wrong at work. Secondly to take a part in building a culture where people feel safe enough at work to speak up.

Working out what is actually going on at work

The first and most important stage of raising concerns is to get an objective and detailed picture of what the problem is. Finding out the

Checking for clues:

As a Guardian you may want to spend some time observing what is not being spoken about at work:

- *spend time every day observing group dynamics and how people relate to each other. Your gut reaction and how you feel during these observations will give you a clue about what is going on under the surface*
- *watch out for changes in atmosphere at work - for example where a previously cheerful team becomes silenced*
- *using anonymous surveys such as wellbeing and stress are good indicators of problem areas*
- *tracking how grievances and conflict are handled - for example whether people that have raised concerns in the past have been victimised or excluded*
- *try to get an accurate picture of the team or organisation including recent history - such as whether there's been a high turnover of staff or recent contracting out of services*

who/what/where/when/whys is not a simple process because it will require you collecting factual evidence, checking it and trying to understand it from different perspectives.

This will involve informal meetings with the complainant, observing the workplace and making your own evidence base. This is a technical and time consuming job of work but it is important to understand the problem before taking action.

This is also an emotional job of work for you as a Guardian - to remain as objective as you can and model the behaviours that you are going to demand of your workplace such as confidentiality, understanding and not blaming the people involved.

Getting informed

As the national guidance for Guardians is developed it will be important for Guardians to use the resources that are already available to answer some key questions:

1. What is the duty of care
2. What constitutes a legitimate concern
3. What informal and formal procedures should you use to raise concerns
4. How to raise a complaint with the CQC

The NHS Constitution and the Local Authority Social Services and NHS Complaints Regulations 2009 include the obligation for staff to ensure that patients area aware of their rights to make a complaint about their care which include:

5. deadlines for responding to verbal and written complaints
6. offering a discussion about the complaint

7. investigation of any complaint and a written response by the responsible person
8. information about taking the complaint to the CQC and the Parliamentary Health Ombudsman

The Duty of Candour

In 2014 a statutory duty of candour was introduced for all health and social care workers to informs patients when something serious has gone wrong with their care and - even when they don't ask for this information - to try to take action to remedy the problem.

Although the duty to raise concerns exists across many regulations and professional standards, the new Duty of Candour will allow for criminal proceedings against individuals who do not inform patients.

"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made." Robert Francis

What constitutes a concern?

Your professional code should be the first place you go to for advice on practices in your workplace. Before you raise a concern you need to distinguish between:

1. Human error: inadvertent action and mistakes
2. At-Risk behaviour: actions that are consciously taken that increase risk. These risks are either not recognised or are believed to be acceptable.
3. Reckless behaviour: where unjustifiable and substantial risk is consciously taken

In order to determine this it may be necessary to talk to the people involved, informally, and encourage them to take other courses of action.

If you are concerned about a workplace issue you should try to speak informally with colleagues about whether they have concerns. A collective complaint will be much more powerful than an individual one and may ensure that action is taken more quickly.

If informal contact does not work then you will need to raise your concerns with your manager. This should be done carefully to avoid 'blame' and including organisational or contextual factors that may be influencing the practice. You may also want to speak to your union representative - particularly if the issues relate to health and safety concerns, workloads or staff shortages.

The most common concerns in health and social care relate to connected issues of:

changes in service delivery such as:

- *outsourcing*
- *work intensification*
- *staff shortages*
- *insufficient skills mix*

In a context of austerity one of the difficult areas for staff is whether to raise concerns over a lack of resources. The advice is that if you know that there is a serious problem with lack of resources and prioritising them then you are obliged to raise your concerns.

" If you knew, or might reasonably have been expected to know, that there were insufficient resources such as competent staff or equipment, then you should have drawn your concerns about this to an appropriate person, normally your line manager int he first instance. The NHS is expected to prioritise care in such a way as to ensure that standards are provided by 'ordinarily competent professionals." Roger Kline.

For health and social care professionals, the duty of care could mean refusing an instruction where you believe they have been ex-

pected to breach their professional code. In this situation, the professional is personally accountable for following their professional code and obliged to refuse instructions on the basis of their duty of care.

Raising concerns

Health and social care professionals have a duty of care to raise concerns about patient safety. This includes identifying specific concerns, recording and collecting evidence of potential risk, cross-checking concerns with policies and protocols and discussing concerns with colleagues.

The most consistent piece of advice is to try to raise concerns informally either directly with the people concerned or with your direct manager, or both. It is advised not to submit a formal concern until other options have been exhausted. The experience of individual grievance handling is that most concerns are dealt with at the early stages of a grievance procedure where the complainant, often accompanied by a union rep, resolves the issue directly with management.

If you have concerns as an individual

Before you start:

- *Be clear about your concerns and their level of urgency*
- *Set out the issues clearly: for yourself, colleagues and mangers*
- *Be clear about the outcomes you are seeking*
- *Talk to colleagues informally about complaining collectively, either informally or informally*
- *Request a meeting with the people concerned*

Good practice shows that when you are raising concerns at a meeting this should involve a presentation of the problem - who/what/when/where -, how the problem undermines clinical care, relevant policies or professional codes, a statement about what action is needed, and if necessary a request for further information. At informal

meetings like these its important to allow managers to respond and also to hold a discussion about the root causes of the problem. Notes should be taken during this meeting and where possible agreement and confirmation on next steps. Sometimes more information and time is needed to work out what action should be taken but this should be clear what the deadlines for this are. After the meeting you should write an email confirming what was discussed and the outcomes. You should also make sure your own notes are up to date - the details of any discussions are important and easy to forget, particularly if emotions were running high.

If you are unable to resolve the problem locally you are obliged to raise your concerns with someone who has 'sufficient authority' to manage the concerns.

Managers have specific obligations for clinical governance which include helping people to report their concerns and helping teams respond to concerns. Some professional codes include the duty of managers to create open and 'just' working cultures where people can raise their concerns without fear of victimization.

If these informal measures don't work then you can pursue the case through the formal workplace procedures, normally a grievance procedure where the alleged harasser can be subject to disciplinary procedures. Remember that the time limit for submitting a grievance is normally 3 months and that by far the best strategy is to involve a trade union.

For further advice on whistleblowing we recommend you contact Public Concern at Work who offer a confidential service. The advice to people considering taking complaints outside of their organisations is to make sure that you have a clear statement of and evidence for your concerns as well as the ability to demonstrate that you have raised your concerns with your employer without success.

Build alliances

Throughout this guide and at the end of the guide you will find some useful guides and handbooks about reassign concerns - many of these are from trade unions who have a long experience of raising concerns and grievances at work.

Checklist for informal meetings

1. BE NICE: remember that whatever is going on the person you are talking to will have been emotionally effected and probably sensitive to how you behave

2. SET THE FRAME: Confirm that the discussion is confidential, that you will take notes but these will not be used and that no action will be taken without their consent

3. LISTEN: Just listen to them. Don't interrupt them or try to give them an answer, just listen

4. ASK QUESTIONS: try to establish the core concern and what action needs to be taken

5. JOINT PLANNING: Agree the way forward one or more of the following:

- *Keeping a written record of incidents*
- *No action to be taken*
- *Informal approach to the people concerned*
- *Formal grievance to be raised*
- *Legal application to be lodged*

6. PHONE A FRIEND: identify people and organisations that need to be contacted to get support

7. BE EXPLICIT: reconfirm with the person what is going to happen next, that the meeting was confidential and that they have your contact details.

8. NOTES: you should always keep notes of any meetings including thoughts and ideas that you have had that may be important in understanding the concern.

Raising Concerns Checklist

- *Are you clear what you are concerned about and why? What evidence do you have and can you get more?*

- *Does this issue affect you or can you raise your concerns collectively? If no one else wants to raise your concerns you should still raise them.*

- *Have you placed your concerns 'on the record'? Even if you raised them verbally it is essential that there is an audit trail. Such evidence is essential to protect patients (and yourself)*

- *Have you set out what you want to achieve? Before you raise your concern, be as clear as you can what you want to achieve.*

- *It is possible to work together with your employer to address your concerns? It may not be, but if it is respond positively.*

- *Check your employers procedures for raising and escalating concerns.*

- *Set out in a single statement what your concerns are, the evidence in support, what you want done, when and why.*

- *If you are offered a meeting don't just turn up for the meeting, prepare for it*

- *Make sure there is a professional, accountable, relationship between those raising concerns and anyone accompanying or representing you such as a trade union rep.*

- *Hope for the best but prepare for the worst. Raising concerns is rarely straightforward and can meet with denial, resistance or worse.*

Roger Kline, Duties of Care

However, it is not the job of a Guardian to raise formal grievances or defend individual members of staff in cases of disciplinaries - this is the job of a legal or union representative so its important where possible that you meet with your union reps and coordinate with them.

Given their expertise in handling grievances and legal knowledge we strongly advise you contact your union rep if you have a union in your workplace. If you need help finding union representation ask colleagues which unions have membership in your workplace - usually this will be Unison or Unite.

Over time it will be important to network with other Guardians and learn from their experience. NHS employers will be developing a 'Guardian's Map' on their website with case studies and identifying the development of FTSU initiatives.

Getting the gaffers on board

Managers also have a responsibility to manage concerns - including having informal meetings and cross checking concerns against policies and standards. Managers are expected to use a wide range of skills in these processes including confidentiality, maintaining channels of communication, following formal procedures.

Managers' and NHS Board members' responsibilities include:

1. putting in place systems and policies that allow for concerns to be raised and investigated
2. ensuring that staff are not restricted or afraid of raising concerns
3. ensuring that staff understand their duty of candour
4. ensuring that people that raise concerns are not victimised or penalised

Probably the key job of work is going to be influencing managers – particularly line managers – whose attitudes are crucial in setting workplace cultures, and management responses when cases of victimisation are raised. Without leadership buy-in to this system, individual guardians will go the way of decades of diversity and equality reps: burnt out and bullied into silence themselves.

In workplaces where these conflicts exist there is likely to be a stigma attached to trying to change things, as a defence against anxiety. Easier to bully a guardian into silence through a ruthless wall of non-cooperation than address the systemic problem of why they are needed in the first place.

Building team working

In management speak this is about building teams where people feel safe to come forward rather than locking themselves in the staff toilets every time there is a staff meeting. It also means creating inclusive teams – involving everyone delivering care from the contract and agency workers, the part timers, the people that raise concerns every single week and the people that you just don't really like. Everyone, across disciplines and employers needs to be involved.

What's new about the Freedom to Speak Up report is that frontline staff started talking. The trick now is to keep them talking about what's really going on, rather than continuing to focus on politically-set targets. The capacity of NHS leadership to deliver these conversations should be the primary measurement of whether they are delivering quality care.

The final section looks at building teams and cultures where people can speak openly with colleagues about how work is done. This is likely to be the biggest barrier to getting people to speak up - that if people are scared and working in a

blame culture even with legal protections and clear policies people will not speak up.

“The healthy organisation is a myth. There isn't such a thing as a health organisation. All orgasniations are going to get stuck because of the impact that the work is having on individuals. That means that its normal for the individual to be overwhelmed by feelings. And normal for the organisation to be overwhelmed by processes that interfere with thinking.”

how to get on with the job

In 2015 social care in the UK went under a serious reality check when the CQC's social care chief, Andrea Sutcliffe, claimed that a chronically underfunded system is "turning good people into bad carers" with 150 complaints about elderly care raised every day. In the same week the Government announced that they will delay a cap on individual 'limited liability' for a further four years and kicked the crisis in social care funding into the safety of the next election.

Our attention has now turned to Buurzorg, a Dutch social care company, that claims to provide a radical model for high quality social care at 65% of the going rate. It does this by getting rid of administrators and letting carers organise their own work.

Set up 6 years ago, Buurtzorg now employs 7000 frontline staff, representing 60% of Dutch community nurses with just 30 managers on its books. The costs per hour are higher but patients need 30-40% less contact time every month. Nurses work in teams of 10 each serving a particular community and working reactively to patient needs. They work closely with local GPs and local services and see themselves as having a key social function identifying and building relationships within the community. Not only are patients happier but so are staff with 60% less staff absenteeism and 33% lower turnover.

Never have 1980s nursing management techniques been so en vogue.

This model of care is in stark contrast to the UK where 160,000 social carers earn less than the minimum wage and social care job vacancies are higher than any other sector.

Most of the people who currently work as carers are the real deal. Women, middle aged, many of whom worked for the public sector and still remember what professional ethics and standards look like. Currently 50% of private providers come from the not-for-profit sector, many of which were set up during privatization. Within the next decade most of these carers will retire and with them goes our heritage of how to manage social care, old school.

Different institutional models

A pragmatic attention to efficiency and cost savings through technology and clinical practice is attractive but the Dutch model comes from a very different institutional setting.

Comparative Employment Relations, sometimes called the Varieties of Capitalism model, offers us a theoretical framework for understanding how and why work is organised differently in different countries. Within this perspective, the UK and Netherlands, despite both being capitalist systems are profoundly different in their approach to providing social care. Two institutional factors really stand out.

The first is that Dutch institutions are framed within a political culture of social democracy and based on strong egalitarian principles. The Dutch & Nordic countries have a shared emphasis on equality, reflected in the lack of pay differentials and a dominant workplace culture of flat leadership. To maintain this equality, the Netherlands has one of the strongest welfare systems in the world.

The second institutional factor relates to employment relations. Although wages by UK standards are moderate, Dutch workers are compensated by a generous 'social wage' including high unemployment benefits, labour protections and social security benefits.

These differences are seen most clearly if we look at flexible work in health and social care sectors. Unlike the UK's often brutal neo-liberal model of high flexibility and insecurity, the Dutch model specifically tries to balance the demand for flexible working with the security needed by flexible workers - in the EU called 'flexicurity'.

The Dutch system protects carers from falling into in-work poverty and de-skilling by having higher protections and investment in skills development. This security includes a higher percentage of flexible workers that are represented by Dutch trade unions, including new unions designed specifically for self-employed workers.

What can we learn from the Dutch?

With a £22 billion efficiency challenge and 'restructuring fatigue' within health and social care, its tempting to go for a technical solution to a political problem. Cut the 48% of non-clinical staff in the NHS and voila we're in Keukenhof?

There's nothing wrong with importing new management ideas - we did it in the 1980s with Japanese production methods - but to do this successfully we have to understand the institutional systems within which they can work.

Cutting bureaucracy is only one part of the socio-political equation, because the Buurtzorg model is one of workplace autonomy and democratic leadership where decision making and setting targets is decentralised to clinical teams. The UK and Netherlands' profoundly different institutional settings mean that to do this successfully would require an enormous shift in both the UK's employment relations and workplace cultures.

Inclusive Leadership

Research indicates that managers under pressure to deliver targets typically default to a command and control management which is unresponsive to both patients and staff. Do-this-now rather than what-is-the-best-we-can-do. This, in turn, is linked to workplace cultures where staff are reluctant to raise concerns, and become disengaged and dysfunctional, a long way from best practice and patient safety.

What we know from the research is that inclusive teams - which promote diversity, working across disciplines and democratic practices - are significantly better at capturing knowledge and promoting organisational learning. Where teams are inclusive they have a tendency to widen the pool of experience and knowledge they have and encourage dialogue and exchange of ideas. This allows for deeper levels of organisational learning which can be linked to increased public sector productivity and patient safety.

Democratic and emotional leadership

At policy level this inclusive model is a no-brainer and gaining widespread support but the difficulty remains in the doing-it-bit.

This is in part because for people to participate at work they have to be allowed to speak their minds, make decisions about their work and challenge their own leadership without penalty.

Within this tradition of Democratic Leadership teams are the primary unit of management and hold the collective responsibility for performance. This model was developed in the manufacturing sector in the 1980s, using a Japanese model of team building - a 'support and stretch' as opposed to a 'control and constrain'

culture which emphasises interdisciplinary and experiential learning and importantly is linked to high clinical results.

All well and good but how do managers actually create democratic cultures when the NHS where most people manage work by keeping their mouths shut and doing what they're told?

One characteristic of inclusive leadership, whether at senior or frontline levels, is to show some emotion. This is not a call for tears in the boardroom or team hugs, rather it's the argument that to deliver democracy at work requires managers to address the deep and often destructive emotions that we all carry to work. From getting to the bottom of bullying to addressing racism in the NHS, the blood and guts of working life that requires both emotional intelligence as well as utter bravery.

Emotional intelligence can be defined as the capacity for self-reflection and self-regulation, empathic qualities which allow us to understand the situation of the people around us, and social skills which allow people to hear and observe reality as it is. In the case of health and social care this inevitably involves experiences of trauma, pain, distress and - not wishing to burst any HRM bubbles - death.

How managers create workplace fear by default

- *fails to provide adequate leadership by not making his intentions or requirements clear*
- *fails to ensure that all staff were adequately trained when new equipment was installed*
- *changes conditions of work without consultation or agreement*
- *continually puts staff under stress by questioning their attitude to work*
- *disputes all medical reasons for absence, even when evidence is provided by the doctor concerned*
- *has made no attempt to instil team spirit within the department, despite the content of their boss's recent memorandum on 'people management'*

In order to do this inclusive leadership prioritises practices of listening, observing, auditing, self-awareness, social-awareness, and emotional management techniques. It is through this emotional capacity that leaders become effective at building teams that are both realistic and resilient rather than grandiose and unresponsive to patient needs.

Inclusive leadership requires a demanding regime of democratic practice and emotional intelligence from executives to frontline managers. This involves a radical departure from the current 'pervasive culture of fear' that operates in the NHS and creating workplaces that are structurally, politically and emotionally open to the people that work within them. A workplace where I can say what's on my mind and you can bear to listen to me.

How to manage work

Firstly, wake up. Nobody will ever come up to you and say "I've got a terrible habit of humiliating my team and making them want to give up and die. Yup, really enjoy it, feel like a king amongst men. Living. The. Dream." So open your eyes, spend a few hours a week just observing your teams and making your own mind up what is not being said in those Monday morning catch ups.

Secondly, feel stuff: Getting people to work under these conditions means you have to be able to make contact with your own and other people's emotions. It means that your capacity to bear the difficult feelings of loss, frustration and anger are paramount in bearing the reality that everyone who works for you has strong feelings about their work.

Thirdly, create safe spaces: Most people don't raise their concerns at staff meetings because they are frightened of being penalised for speaking their mind. To talk openly we all need to feel we are in a safe space to do this - and that's the job of a manager to try to create new or existing spaces so that people can speak openly to each other. Methods for doing this often come from adult education,

and focus around Action Learning Sets or workplace supervision groups. It means establishing some ground rules for conduct, including respect and confidentiality, important for people to say what is really on their mind. A good model for medical practitioners is used by The Balint Group and the Schwartz Centre. Other potential safe spaces include CPD workshop or taking a lead in team meetings - the key is to create spaces where colleagues are able to safely discuss their work.

Finally, become a pedant: The details of work matter, massively. It matters if you define appropriate and inappropriate workplace behaviours, that your policies on speaking up guarantee confidentiality, that you give great training for all workers about diversity and really clear guidance on raising concerns.

The principles of Surviving Work

Whether you're a frontline worker or manager, because of the emotional nature of working in health and social care to do any of this workers have to be clear about how to orientate themselves at work. Based on the Surviving Work Library and your contributions on the question 'how do you survive work?' here is a summary of top tips for surviving work.

Don't blame yourself: health and social care workers have a huge capacity to blame themselves for the state of the world. It is therefore important to understand the context that you are working within and to identify what parts you're responsible for and what parts you have no control over.

Don't stay calm and carry on: This is a tricky one for clinicians and carers who when they are working with patients very much need to be in control of their emotions. But if we are not able to experience and also express our feelings at some point we will become cut off from other people. This will affect our capacity to address the emotional needs of patients and also our ability to form solid relationships.

Don't be brilliant: again not something that most high achieving clinicians want to hear but the reality is you are just a human being. One of the worst things you can do is set yourself impossible challenges. If you can be more realistic about what you can do you will find yourself in a much stronger position to do some good work in a very demanding environment.

Don't go it alone: whichever way you look at it you stand a much greater chance of surviving work if you have people who you like and can talk to. Crisis brings us face to face with one of the unavoidable facts of life that we are all dependent on each other. As the containment of public services breaks down social anxiety goes up and the temptation is to manage this by projecting our vulnerability into others. Even by drawing borders between people - between the sick and the fit, scroungers and hard working people - we can never successfully cut ourselves off from the reality that as human beings we are inherently vulnerable. Whether it's a colleague, a union rep or someone outside work, at some point you should tell someone what you need and ask them if they can help.

Relational model of care

Against our commodified model of care stands a relational model of care. A model that argues that relationships with each other - not just about with the patient but between staff - has to take priority. A relational model of solidarity where we can make the best of a bad lot without fear of victimisation. This involves being strategic about what battle lines you draw and sticking to your principles. In health and social care, our ideals become compromised every day - our duty is to not let them become so squeezed the reality of working life crushes the care out of us.

In today's workplace relationships are priceless. It does mean accepting the uncomfortable, irritating and often ridiculous behaviour and views of other people.

When you've got over that, you might find that some of them are actually quite nice and interested in doing a good job. They might not love you or think you're a hero but they can help you move from a victim of work to a survivor of work. Speaking up at work

Action Learning Sets

What is an action learning set?

It is a group of people meeting regularly, bringing and sharing work events, experience, feelings and ideas, to be worked on with the rest of the group. Action learning involves dialogue, reflection, and collective pro blame solving and is consistent with the methods and principles of adult education that is used by the WEA and Trade Unions.

Principles and practices

The groups are set up to run according to a set of principles.

1. confidentiality of the discusions
2. everyone is equal in the group
3. voluntary attendance but commitment to attend regularly
4. commitment made by participants to share their knowledge and experiences and to listen and learn from each other
5. commitment to collective problem solving and planning that comes out of the group

How to organize an action learning set

One of the great things about ALSs is that they can be flexible to their environment. You can run them for 1.5 hours to half a day, normally no more than 10 members approximately once or twice a month.

Most new groups will have a regular facilitator with some experience of workplace supervision (such as psychotherapists or other clinicians). However it depends on the groups experience and in health settings you often find rotating facilitation.

Meetings normally start with people doing a quick update of where they are. In health settings it is often the case that the group will focus on one critical incident

- with a short report and then an open discussion about how to understand it and what can be taken about it. Normally the presenter will listen to the groups reactions and then reflect on what they have learned at the end. Groups can set themes, like bullying or racism, and are expected to find collective solutions and actions to take away with them.

where to go next

Core resources

Throughout this guide there are hyperlinks to current research and reports.
A workplace essential is Your Rights at Work: A TUC Guide 4th Edition. Just buy it.

The Guides we recommend about handling workplace issues are:

1. Zero Tolerance: Dignity at Work, UNITE
2. Understanding Grievances and Disciplinaries, TUC
3. Discipline and Grievances at Work: The ACAS Guide
4. Draw the Line: A managers guide to raising concerns, NHS Employers
5. The Duty of Care of Healthcare Professionals, Roger Kline with Shazia Khan
6. Clinical Commissioning Groups and the Workforce Race Equality Standard, Roger Kline and Yvonne Coghill

Useful stuff online

Before you go online make sure you use a personal email account and any lists or groups you join you use personal contact details. If you are new to social media start out using an anonymous account and then decide about what profile you'd like to present online when you've got an idea about what can be seen publicly. If in doubt don't post it!

Disabled People Against the Cuts http://dpac.uk.net

Recovery in the Bin http://recoveryinthebin.org

Critical Mental Health Nursing http://criticalmhnursing.org/about-us/

Psychologists Against Austerity

https://psychagainstausterity.wordpress.com

The Academy of Fabulous NHS Stuff http://www.fabnhsstuff.net

Health Campaigns Together http://healthcampaignstogether.com

Mental Health Task Force

https://www.england.nhs.uk/mentalhealth/2016/02/15/fyfv-mh/

NHS Reinstatement Bill Petition 11th March 2016

http://www.nhsbill2015.org

Keep our NHS Public http://keepournhspublic.com

Big Up the NHS http://www.bigupthenhs.com

Surviving Work Survey & Blog www.survivingwork.org

Centre for Health in the Public Interest http://chpi.org.uk

Psychotherapy & Counselling Union (PCU)

https://lechatdargent.wordpress.com/2015/10/02/join-the-psychotherapy-and-counselling-union/

Psychotherapists and Counsellors for Social Responsibility

http://pcsr-uk.ning.com/page/about-us

Alliance for Counselling & Psychotherapy
http://alliance.drupalgardens.com

Socialist Health Association http://www.sochealth.co.uk

Unison, Mental Health Section

https://www.unison.org.uk/at-work/health-care/

Unite, Mental Health Section

http://www.unitetheunion.org/how-we-help/list-of-sectors/healthsector/

Social Media

1. Surviving Work Library www.survivingwork.org/library-2

2. Frontier Psychoanalyst, David Morgan & Resonance FM https://www.mixcloud.com/Resonance/frontier-psychoanalyst-pilot-11-december-2015/

3. To hear people talk anonymously about their experiences of bullying at work go to the Surviving Work Library here http://survivingwork.org/bullying/
4. An interesting social media campaign is #Hellomynameis which is encouraging doctors to be more emotionally engaged with each other and patients set up by Kate Granger, a doctor who is also a cancer patient and who tweets as @GrangerKate
5. A useful online and face to face medical reading group is @TwitJournalClub
6. A good individual and anonymous online mental health service is the Big White Wall http://www.bigwhitewall.com

7. @RogerKline @survivingwk @clarercgp @NHSBillNow @DrJackyDavis @DrTonyOSullivan @RoyLilley @Dis_PPL-Protest @Chrissox

Books

Some really good books about working in health care are:

1. Allyson Pollock: NHS plc: The Privatization of our health care (Vergo)
2. Joh Burton: Leading good care: the task, heart and art of managing social care (Jessica Kingsley Publishers)

3. Jody Hoffer Gittell: High Performance healthcare: Using the power of relationships to achieve quality, efficiency and resilience (MdGraw Hill)
4. Roger Taylor: God bless the NHS: The truth behind the current crisis (Faber & Faber)
5. Louise Grant and Gail Kinman: Developing resilience for social work practice (Palgrave)
6. Atul Gawande: The Checklist Manifesto: How to get things right (Profile Books)
7. James Prochaska, John Norcross & Carlo Diclemente: Changing for Good (Harper Collins)
8. For information about Balint Groups http://balint.co.uk
9. For information on Schwarz Rounds http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/schwartz-center-rounds-pilot-evaluation-jun11.pdf
10. NHS SOS, Jacky Davis & Raymond Tallis
11. The Plot Against the NHS, Colin Leys & Stewart Player

Psychoanalytic perspectives on work and health:

1. David Armstrong: Organization in the mind: psychoanalysis, Group Relations and organisational consultancy (Karnac)
2. David Armstrong and Michael Rustin: Social defences against anxiety: Explorations in a paradigm (Karnac)
3. David Bell: Psychoanalysis and Culture: A Kleinian Perspective (Routledge)

Some good background reading (as if you had the time….):

1. Michael Marmot: The health gap: the challenge of an unequal world (Bloomsbury)
2. Peter Fleming: Resisting Work: The corporatization of life and its discontents (Temple University Press)
3. Srdja Popovic & Mathew Miller: Blueprint for Revolution: How to use rice pudding, lego men, and other non-violent techniques to galvanise communities, overthrow dictators or simply change the world (Scribe)

The four books we recommend about bullying are:

1. Andrea Adams & Neil Crawford: Bullying at work: how to confront and overcome it (Virago)
2. Tim Field: Bully in Sight: how to predict, resist, challenge and combat workplace bullying (Success Unlimited)
3. Anne-Marie Quigg: The handbook of dealing with workplace bullying (Gower)

4. Sheila White: An introduction to the psychodynamics of workplace bullying (Karnac)

Note: If you are concerned about suicide you need to speak to your own doctor, or alternatively speak to the Samaritans on 08457909090. They are brilliant. Put this number in your phone right now

Survivingwork